

WELCOME TO OUR OFFICE

Last Name: _____ First Name: _____
SS #: _____ Date of Birth: ____/____/____
Address: _____ City: _____ State: _____
Zip Code: _____ E: MAIL: _____
Your e-mail will not be shared with any 3rd parties, for general office announcements, and promotions
Home Ph: _____ Work. Ph: _____ Cell: _____
Sex Male Female Marital Status: Single Married Widowed Divorced Partnered for ____ years
Occupation: _____ Employer: _____
Emergency Contact: _____ Phone: _____
Who may we thank for referring you? _____

Insurance Information:

PLEASE LEAVE A COPY OF CARD

Insurance Co. _____ Group Plan Individual
Group # _____ ID# _____
Subscribers Name: _____ Date of Birth: _____ SS# _____
Attorney: _____ Ph: _____

Full Payment of your Co-pay is **DUE AT THE TIME OF SERVICE**. Insurance is a contract between you and your insurance company. We file claims as a courtesy to our patients. You are responsible for all non covered charges and denied services.

ASSIGNMENT and RELEASE

I the undersigned, assign directly to my physician all medical benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether of not paid by my insurance. I authorize the use of my signature on all insurance submissions

Signature of Patient/Guardian

Date: _____